		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038711

Facility Name: Embassy Care Center, Inc

Address: 555 Kahler Road
Number City Zip Code

County: Will

Telephone Number: (815) 476-7931 **Fax #** (815) 476-7939

IDPA ID Number: 36-3863655-001

Date of Initial License for Current Owners: 02/01/93

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL
☐ Charitable Corp.	☐ Individual	☐ State
☐ Trust	☐ Partnership	☐ County
IRS Exemption Code ____	☐ Corporation	☐ Other ____
	☒ "Sub-S" Corp.	
	☐ Limited Liability Co.	
	☐ Trust	
	☐ Other ____	

In the event there are further questions about this report, please contact:
Name: Bob Kagda **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Bob Kagda, Partner
(Firm Name & Address) Krupnick, Bokor, Kagda & Brooks, Ltd. 3750 W. Devon Ave. Lincolnwood, Il 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3	91	Intermediate (ICF)	91	33,215	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,415	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,978	1,978	8
9	SNF/PED					9
10	ICF	27,034	9,380	92	36,506	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,034	9,380	2,070	38,484	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.66%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 1,978

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	202,747	17,322	7,600	227,669		227,669		227,669			1
2	Food Purchase		167,677		167,677	(19,901)	147,776	(405)	147,371			2
3	Housekeeping	139,761	27,966		167,727		167,727		167,727			3
4	Laundry	68,813	14,359		83,172		83,172		83,172			4
5	Heat and Other Utilities			96,918	96,918		96,918	2,618	99,536			5
6	Maintenance	46,870		33,360	80,230		80,230	2,982	83,212			6
7	Other (specify):*											7
8	**TOTAL General Services**	458,191	227,324	137,878	823,393	(19,901)	803,492	5,195	808,687			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,107,302	81,086	181,285	1,369,673		1,369,673	57,983	1,427,656			10
10a	Therapy	79,841	658	15,826	96,325		96,325		96,325			10a
11	Activities	87,901	9,827	2,940	100,668		100,668		100,668			11
12	Social Services	39,742		4,812	44,554		44,554		44,554			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,314,786	91,571	210,863	1,617,220		1,617,220	57,983	1,675,203			16
	C. General Administration											
17	Administrative	77,401		296,007	373,408		373,408	(251,187)	122,221			17
18	Directors Fees											18
19	Professional Services			49,286	49,286		49,286	(3,478)	45,808			19
20	Dues, Fees, Subscriptions & Promotions			12,733	12,733		12,733	(6,885)	5,848			20
21	Clerical & General Office Expenses	109,347	18,385	54,378	182,110		182,110	31,582	213,692			21
22	Employee Benefits & Payroll Taxes			314,120	314,120	19,901	334,021	5,170	339,191			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,103	1,103		1,103		1,103			24
25	Other Admin. Staff Transportation			10,257	10,257		10,257	1,234	11,491			25
26	Insurance-Prop.Liab.Malpractice			157,808	157,808		157,808	1,448	159,256			26
27	Other (specify):*											27
28	**TOTAL General Administration**	186,748	18,385	895,692	1,100,825	19,901	1,120,726	(222,116)	898,610			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,959,725	337,280	1,244,433	3,541,438		3,541,438	(158,938)	3,382,500			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Embassy Care Center, Inc
0038711
COST REPORT RECLASSIFICATIONS
01/01/02
12/31/02

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	19,901	
2	FOOD		19,901

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number Embassy Care Center, Inc #0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			36,091	36,091		36,091	102,474	138,565			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,382	53,382		53,382	504,729	558,111			32
33	Real Estate Taxes			60,823	60,823		60,823	4,230	65,053			33
34	Rent-Facility & Grounds			561,371	561,371		561,371	(561,371)				34
35	Rent-Equipment & Vehicles							2,470	2,470			35
36	Other (specify):*											36
37	**TOTAL Ownership**			711,667	711,667		711,667	52,532	764,199			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		82,443	35,135	117,578		117,578		117,578			39
40	Barber and Beauty Shops			1,739	1,739		1,739		1,739			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			93,623	93,623		93,623		93,623			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		82,443	130,497	212,940		212,940		212,940			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,959,725	419,723	2,086,597	4,466,045		4,466,045	(106,406)	4,359,639			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,892	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(405)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(3,327)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,637)	21		24
25	Fund Raising, Advertising and Promotional	(3,797)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(66,677)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (81,951)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(24,455)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (24,455)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (106,406)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Embassy Care Center, Inc

ID# **0038711**

Report Period Beginning: **01/01/02**

Ending: **12/31/02**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	From Embassy Building Partnership:	$		1
2	Trust Fees	(300)	21	2
3	Bank Charges	(746)	21	3
4	Non Patient Care - Interest Exp	(9,864)	32	4
5	R E Taxes	(3,676)	33	5
6	Mtgre Costs	(5,630)	32	6
7	Depreciation House	(3,846)	30	7
8				8
9	Interest Income	(26)	32	9
10	Veterans Expenses	(2,017)	10	10
11	Marketing Salaries	(23,905)	21	11
12	Bank Charges	(12,955)	21	12
13	Marketing Charges	(5,705)	19	13
14	Prior Year Data Proc cost	(69)	19	14
15	Deferred Maintenance	(1,781)	6	15
16	Deferred Maintenance	3,843	6	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(66,677)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Embassy Care Center, Inc # 0038711 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(405)	0	0	0	0	0	0	0	0	0	0	(405)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,618	0	0	0	0	0	0	0	0	2,618	5
6	Maintenance	2,062	0	920	0	0	0	0	0	0	0	0	2,982	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,657	0	3,538	0	0	0	0	0	0	0	0	5,195	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,017)	0	60,000	0	0	0	0	0	0	0	0	57,983	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,017)	0	60,000	0	0	0	0	0	0	0	0	57,983	16
	C. General Administration													
17	Administrative	0	0	(251,187)	0	0	0	0	0	0	0	0	(251,187)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,774)	0	2,296	0	0	0	0	0	0	0	0	(3,478)	19
20	Fees, Subscriptions & Promotions	(7,124)	0	239	0	0	0	0	0	0	0	0	(6,885)	20
21	Clerical & General Office Expenses	(64,543)	1,362	94,763	0	0	0	0	0	0	0	0	31,582	21
22	Employee Benefits & Payroll Taxes	0	0	5,170	0	0	0	0	0	0	0	0	5,170	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	1,234	0	0	0	0	0	0	0	0	1,234	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,448	0	0	0	0	0	0	0	0	1,448	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(77,441)	1,362	(146,037)	0	0	0	0	0	0	0	0	(222,116)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(77,801)	1,362	(82,499)	0	0	0	0	0	0	0	0	(158,938)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Embassy Care Center, Inc # 0038711 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	15,046	78,862	8,566	0	0	0	0	0	0	0	0	102,474	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,520)	512,880	7,369	0	0	0	0	0	0	0	0	504,729	32
33	Real Estate Taxes	(3,676)	3,676	4,230	0	0	0	0	0	0	0	0	4,230	33
34	Rent-Facility & Grounds	0	(561,371)	0	0	0	0	0	0	0	0	0	(561,371)	34
35	Rent-Equipment & Vehicles	0	0	2,470	0	0	0	0	0	0	0	0	2,470	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,150)	34,047	22,635	0	0	0	0	0	0	0	0	52,532	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(81,951)	35,409	(59,864)	0	0	0	0	0	0	0	0	(106,406)	45

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule	See Schedule			See Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	Rent	$ 561,371			$	$ (561,371)	1
2	V		\							2
3	V		21	Bank Charges				746	746	3
4	V		21	Trust Fees				300	300	4
5	V		32	Interest Expense				507,258	507,258	5
6	V		33	RE Tax				3,676	3,676	6
7	V		30	Depreciation				78,862	78,862	7
8	V		32	Amort Mtge Costs				5,630	5,630	8
9	V		21	Office Expense				316	316	9
10	V		32	Interest Income				(8)	(8)	10
11	V									11
12	V									12
13	V									13
14	Total				$ 561,371			$ 596,780	$ * 35,409	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 296,007	Future Associates	100.00%	$	$ (296,007)	15
16	V	5	Utilities		Future Associates	100.00%	2,618	2,618	16
17	V	6	Maintenance		Future Associates	100.00%	920	920	17
18	V	17	Administrative		Future Associates	100.00%	44,820	44,820	18
19	V	19	Professional Fees		Future Associates	100.00%	2,296	2,296	19
20	V	21	Clerical and General		Future Associates	100.00%	94,763	94,763	20
21	V	22	Employee Benefits		Future Associates	100.00%	5,170	5,170	21
22	V	25	Auto Expense		Future Associates	100.00%	1,234	1,234	22
23	V	26	Insurance Expense		Future Associates	100.00%	1,448	1,448	23
24	V	30	Depreciation		Future Associates	100.00%	8,566	8,566	24
25	V	32	Interest Expense		Future Associates	100.00%	7,369	7,369	25
26	V	33	Real Estate Taxes		Future Associates	100.00%	4,230	4,230	26
27	V	35	Equipment Rental		Future Associates	100.00%	2,470	2,470	27
28	V	20	License, Dues, Fees		Future Associates	100.00%	239	239	28
29	V	10	Nursing Services		Future Associates	100.00%	60,000	60,000	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 296,007			$ 236,143	$ * (59,864)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Haim Perlstein	Director	Administrative	22.96	See attached	27	45.00	Admin	$ 44,820	17-7	1
2											2
3	Nachshon Draiman	Director	Administrative	70.40							3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 44,820		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Future Associates
Street Address: 7514 N. Skokie Blvd
City / State / Zip Code: Skokie, Il
Phone Number: (847)982-1195
Fax Number: (847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Management Fees	1,088,122	4	$ 9,622	$	296,007	$ 2,618	1
2	6	Maintenance	Management Fees	1,088,122	4	3,382		296,007	920	2
3	17	Administrative	Direct allocation		4	210,600			44,820	3
4	19	Professional Fees	Management Fees	1,088,122	4	8,439		296,007	2,296	4
5	21	Clerical and General	Management Fees	1,088,122	4	348,350	280,707	296,007	94,763	5
6	22	Employee Benefits	Management Fees	1,088,122	4	19,004		296,007	5,170	6
7	25	Auto Expense	Management Fees	1,088,122	4	4,537		296,007	1,234	7
8	26	Insurance Expense	Management Fees	1,088,122	4	5,322		296,007	1,448	8
9	30	Depreciation	Management Fees	1,088,122	4	31,490		296,007	8,566	9
10	32	Interest Expense	Management Fees	1,088,122	4	27,089		296,007	7,369	10
11	33	Real Estate Taxes	Management Fees	1,088,122	4	15,548		296,007	4,230	11
12	35	Equipment Rental	Management Fees	1,088,122	4	9,080		296,007	2,470	12
13	20	License, Dues, Fees	Management Fees	1,088,122	4	877		296,007	239	13
14	21	Clerical and General	Direct allocation		4	44,804	44,804			14
15	22	Employee Benefits	Direct allocation		4	3,608				15
16	10	Nursing Costs	Direct allocation		4	60,000			60,000	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 801,752	$ 325,511		$ 236,143	25

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CIB Bank		X	Mortgage	$43,220.44	12/30/99	$ 4,510,000	$		9.7500	$ 460,861	1
2	Hawthorn Bank		X	Working Capital						Various	36,533	2
3	Minolta		X	Capital Lease - Equip	$1,066.00	12/31/99	21,285			18.3620	388	3
4												4
5												5
	Working Capital											
6	CIB Bank		X	Working Capital		12/99				Various	35,975	6
7	Insurance		X								9,245	7
8	Provider License Fee		X								4,584	8
9	TOTAL Facility Related				$44,286.44		$ 4,531,285	$			$ 547,586	9
	B. Non-Facility Related*											
10												10
11	See Supplemental Page 9										3,182	11
12	Interest Income										(26)	12
13	Allocation from Future										7,369	13
14	TOTAL Non-Facility Related						$	$			$ 10,525	14
15	TOTALS (line 9+line14)						$ 4,531,285	$			$ 558,111	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	RE Tax		X								3,177	6
7	Illinois Dept of Revenue		X								13	7
8												8
9	TOTAL Facility Related						$ 0	$ 0			$ 3,190	9
	B. Non-Facility Related*											
10												10
11	Bank Financial		X	Mortgage - Non Care	$933.00	4/1/96	120,000	112,503		8.6250	9,864	11
12	Adjustment										(9,864)	12
13	Interest Income										(8)	13
14	TOTAL Non-Facility Related				$933.00		$ 120,000	$ 112,503			$ (8)	14
15	TOTALS (line 9+line14)						$ 120,000	$ 112,503			$ 3,182	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Embassy Care Center, Inc # 0038711 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 60,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 64,553	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,553	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 60,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 65,053	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	53,199	8
	1998	53,454	9
	1999	54,781	10
	2000	56,677	11
	2001	60,323	12

Estimate based on 2001 bill adjusted to 60,500

Allocation from Future 4230

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Embassy Care Center, Inc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0038711

CONTACT PERSON REGARDING THIS REPORT Bob Kagda

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-17-36-300-010-0000	Nursing Home	$ 60,323.00	$ 60,323.00
2.	10-28-408-025	Management Office	$ 17,878.19	$ 1,382.00
3.	10-28-408-026	Management Office	$ 8,732.66	$ 675.00
4.	10-28-408-027	Management Office	$ 8,732.66	$ 675.00
5.	10-28-408-028	Management Office	$ 12,675.01	$ 980.00
6.	10-28-408-029	Management Office	$ 12,675.01	$ 980.00
7.	10-28-408-030	Management Office	$ 1,518.93	$ 117.00
8.	10-28-408-031	Management Office	$ 1,518.93	$ 117.00
9.			$	$
10.			$	$
		TOTALS	$ 124,054.39	$ 65,249.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1993	$ 145,000	1
2					2
3	TOTALS			$ 145,000	3

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	171			1993	$ 2,363,000	$ 75,016	35	$ 67,514	$ (7,502)	$ 669,514	4
5											5
6	Alloc LCF		1986		59,122	2,483	30	1,971	(512)	31,696	6
7	Alloc LCF		1987		1,418	45	31.5	45		698	7
8											8
	Improvement Type**										
9											9
10	Various			1993	55,674	1,096	20	2,784	1,688	26,345	10
11	Various			1994	144,492	2,935	30	7,227	4,292	61,700	11
12	Various			1995	126,250	3,222	20	6,316	3,094	47,136	12
13	Various			1996	94,458	2,424	20	4,723	2,299	30,974	13
14	Various			1997	13,974	358	20	700	342	4,086	14
15	Various			1998	13,694	219	20	687	468	3,019	15
16	Shower Faucets			1999	1,717	44	20	86	42	344	16
17	Floor Water Leak			1999	1,175	30	20	59	29	236	17
18	Fire Alarm Door			1999	711	18	20	36	18	138	18
19	New Cable For PA Sys			1999	624	16	20	31	15	119	19
20	Rear Door Alarm			1999	876	22	20	44	22	169	20
21	Fire Alarm Cables			1999	887	23	20	44	21	169	21
22	Couplings Mounts			1999	526	13	20	26	13	98	22
23	Wood Door			1999	932	24	20	47	23	172	23
24	Heat sensors			1999	1,523	39	20	76	37	272	24
25	Heat Detectors			1999	650	17	20	33	16	113	25
26	Outlets and Cable			1999	825	21	20	41	20	137	26
27	Nurse call system			1999	634	16	20	32	16	107	27
28	Cable Outlets - DON			1999	557	14	20	28	14	93	28
29	Window Glass			1999	645	17	20	32	15	107	29
30	New Drain Pipe			1999	3,000	77	20	150	73	488	30
31	Carrier Board			1999	668	17	20	33	16	105	31
32	Water Main			1999	683	18	20	34	16	108	32
33	Rep. 2.5 WaterMain			1999	2,200	56	20	110	54	348	33
34	Fire Alarm System			1999	1,220	31	20	61	30	193	34
35	Extend PA System			1999	1,381	35	20	69	34	219	35
36	Door Lock System			1999	1,463	38	20	73	35	231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roof Top Units	1999	$ 553	$ 14	20	$ 28	$ 14	$ 86	37
38	Alarm System	1999	721	18	20	36	18	111	38
39	Boiler	1999	5,455	140	20	273	133	842	39
40	Clean floors	2000	872	22	20	87	65	232	40
41	100 A 240 V 3 POLE	2000	809	21	20	40	19	103	41
42	Painting & Decor	2000	44,888		20	2,244	2,244	4,548	42
43	Single stage furnace	2000	2,891	74	20	145	71	350	43
44	Hot water heater	2000	2,500	64	20	250	186	542	44
45	Nurse call system	2000	750	19	20	38	19	82	45
46	Install h/water htr	2000	850	22	20	43	21	93	46
47	New Grease Trap	2000	15,037	386	20	752	366	1,567	47
48	Alarm system	2001	1,691	43	20	85	42	128	48
49	Sewer rodding	2001	1,265	32	20	63	31	74	49
50	Wire fire alarm system	2001	756	19	20	19		25	50
51	CCTV service	2001	945	24	20	47	23	55	51
52	Alarm system	2002	1,466	33	20	61	28	61	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,976,428	$ 89,315		$ 97,323	$ 8,008	$ 888,033	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,976,428	$ 89,315		$ 97,323	$ 8,008	$ 888,033	1
2	Allocation from LCF	1987	8,137	258	31.5	258		3,939	2
3	Allocation from LCF	1988	457	14	31.5	14		208	3
4	Allocation from LCF	1989	170	5	31.5	5		72	4
5	Allocation from LCF	1993	4,726	121	39	121		1,135	5
6	Allocation from LCF	1994	7,207	185	39	185		1,562	6
7	Allocation from LCF-Air Cond; Roof repairs	2001	2,007	51	39	51		76	7
8	Allocation from LCF-5 Ton Trane A/C	2002	492	5	39	5		5	8
9	Allocation From Future	1987	25,643	814	31.5	827	13	13,141	9
10	Allocation From Future	1994	7,500	102	Var	455	353	4,044	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,032,767	$ 90,870		$ 99,244	$ 8,374	$ 912,215	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 356,247	$ 23,929	$ 36,119	$ 12,190	10	$ 213,653	71
72	Current Year Purchases	40,089	2,936	830	(2,106)	10	830	72
73	Fully Depreciated Assets	434,580		433	433	10	434,580	73
74								74
75	TOTALS	$ 830,916	$ 26,865	$ 37,382	$ 10,517		$ 649,063	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Bus	1993 Ford Bus	1998	$ 1,200	$ 138	$ 139	$ 1	5	$ 1,131	76
77	Alloc from Future			50,922	1,798	1,798		5	30,228	77
78										78
79										79
80	TOTALS			$ 52,122	$ 1,936	$ 1,937	$ 1		$ 31,359	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,060,805	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 119,671	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 138,563	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,892	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,592,637	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	House	$ 150,000	$ 3,846	$ 25,800	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 150,000	$ 3,846	$ 25,800	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation from Future		$	$ 2,470	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,470	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 2,863	$		$ 2,863	1
2	Licensed Speech and Language Development Therapist		hrs			5,479			5,479	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			26,793			26,793	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				52,894		52,894	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Med Supplies	39-2					29,549		29,549	13
14	TOTAL			$		$ 35,135	$ 82,443		$ 117,578	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Embassy Care Center, Inc # 0038711 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 71,492	$ 79,832	1
2	Cash-Patient Deposits	39,524	39,524	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 110,000)	992,530	1,007,145	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	138,737	138,737	6
7	Other Prepaid Expenses	3,352	3,352	7
8	Accounts Receivable (owners or related parties)	714,448	1,506,934	8
9	Other(specify):	34,591	42,294	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,994,674	$ 2,817,818	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		145,000	13
14	Buildings, at Historical Cost		2,513,000	14
15	Leasehold Improvements, at Historical Cost	459,628	459,628	15
16	Equipment, at Historical Cost	378,546	770,546	16
17	Accumulated Depreciation (book methods)	(391,578)	(1,550,161)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Utility Dep	3,478	3,478	22
23	Other(specify): Mtge Costs		95,716	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 450,074	$ 2,437,207	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,444,748	$ 5,255,025	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,395,123	$ 1,417,196	26
27	Officer's Accounts Payable	1,698,512		27
28	Accounts Payable-Patient Deposits	34,422	34,422	28
29	Short-Term Notes Payable	480,269	993,269	29
30	Accrued Salaries Payable	215,937	215,937	30
31	Accrued Taxes Payable (excluding real estate taxes)	55,283	55,283	31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,500	64,000	32
33	Accrued Interest Payable	3,252	41,775	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Schedule attached			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,943,298	$ 2,821,882	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,385,008	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Schedule attached			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,385,008	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,943,298	$ 7,206,890	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,498,550)	$ (1,951,865)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,444,748	$ 5,255,025	48

***(See instructions.)**

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES As of 12/31/02

OTHER CURRENT ASSETS:	Amount	Amount	OTHER CURRENT LIABILITIES:	Amount	Amount
Real Estate Tax Escrow	22,073	29,776	Accrued Expenses		
Deferred Federal Taxes	12,518	12,518			
	34,591	42,294			
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
Construction In Progress					
Utility Deposit					
Loan Costs					

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,289,859)	1
2	Restatements (describe):		2
3	**Round Off adj**	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,289,857)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(208,693)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (208,693)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,498,550)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,153,934	1
2	Discounts and Allowances for all Levels	(98,780)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,055,154	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	98,483	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 98,483	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,737	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	56,084	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	33,065	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 90,886	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Schedule attached (Pg19_Supp)	12,803	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,803	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,257,352	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	823,393	31
32	Health Care	1,617,220	32
33	General Administration	1,100,825	33
	B. Capital Expense		
34	Ownership	711,667	34
	C. Ancillary Expense		
35	Special Cost Centers	119,317	35
36	Provider Participation Fee	93,623	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,466,045	40
41	**Income before Income Taxes (line 30 minus line 40)****	(208,693)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (208,693)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **Embassy Care Center, Inc** **# 0038711** **Report Period Beginning:** **01/01/02** **Ending:** **12/31/02**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/02

	DESCRIPTION		AMOUNT
1	Vending Commissions		
2	Adj of Prior period Income		10,792
3	Adj of Prior period Expenses:		
4	Accounting	26729	
5	PT; OT; Act Cons	-23176	
6	Union Dues	-2542	
7	Bank Recon Adj from 12/2001	1000	2,011
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
	TOTALS		12,803

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,875	2,439	$ 51,968	$ 21.31	1
2	Assistant Director of Nursing	1,384	1,410	31,731	22.50	2
3	Registered Nurses	4,841	5,754	118,356	20.57	3
4	Licensed Practical Nurses	18,241	19,733	345,916	17.53	4
5	Nurse Aides & Orderlies	51,938	56,785	559,331	9.85	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,417	6,026	79,841	13.25	8
9	Activity Director	3,613	4,204	41,286	9.82	9
10	Activity Assistants	6,197	6,621	46,615	7.04	10
11	Social Service Workers	3,592	4,241	39,742	9.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,392	25,124	202,747	8.07	15
16	Dishwashers					16
17	Maintenance Workers	3,788	4,148	46,870	11.30	17
18	Housekeepers	17,688	19,041	139,761	7.34	18
19	Laundry	9,690	10,255	68,813	6.71	19
20	Administrator	3,347	3,494	62,097	17.77	20
21	Assistant Administrator	594	818	15,304	18.71	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,611	9,644	85,442	8.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify) Marketing	1,672	1,715	23,905	13.94	33
34	TOTAL (lines 1 - 33)	164,880	181,452	$ 1,959,725 *	$ 10.80	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	162	$ 7,600	1-3	35
36	Medical Director	Monthly	6,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,950	10-3	39
40	Physical Therapy Consultant	Monthly	14,881	10a-3	40
41	Occupational Therapy Consultant	18	945	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	56	2,940	11-3	44
45	Social Service Consultant	82	4,812	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	318	$ 39,128		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,976	$ 128,236	10-3	50
51	Licensed Practical Nurses	257	12,169	10-3	51
52	Nurse Aides	1,105	38,930	10-3	52
53	TOTAL (lines 50 - 52)	7,338	$ 179,335		53

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
William Bersted	Admin	0	$ 55,494
Kim Forrest	Asst Admin	0	20,462
Barb Faron	Admin	0	5,950
Year end Accrual Adjustment			(4,505)
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,401

B. Administrative - Other

Description	Amount
Future Associates	$ 296,007
TOTAL (agree to Schedule V, line 17, col. 3)	$ 296,007
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	UC Consultant	$ 712
Krupnick,Bokor, Kagda, & Brooks	Acctg	5,200
L J Cohn	Acctg	12,983
R Peelo	Medicare Acctg	3,500
S Streifler Mktg and Others	Marketing	5,705
Various	Data Processing	9,959
Sachnoff & Weaver	Legal	11,227
Schedule attached		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 49,286

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,555
Unemployment Compensation Insurance	13,130
FICA Taxes	149,920
Employee Health Insurance	83,416
Employee Meals	19,901
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	830
Holiday Expense	15,269
Allocation from Future	5,170
TOTAL (agree to Schedule V, line 22, col.8)	$ 339,191

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,478
Health Care Worker Background Check	
(Indicate # of checks performed)	
Advertising	3,797
Dues and Subscriptions	390
Meals	3,327
Licenses and Fees	1,741
Allocation from Future	239
Less: Public Relations Expense	( )
Non-allowable advertising	(7,124)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,848

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,103
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,103

* Attach copy of IMRF notifications

**See instructions.

Embassy Care Center, Inc **0038711**

01/01/02 to **12/31/02**

Page 21- Professional Services:

-

Facility Name & ID Number Embassy Care Center, Inc # 0038711 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Painting & Decorating	6/99	$ 16,586	3	$ 2,764	$ 5,529	$ 5,529	$ 2,764	$	$	$	$	$
2	Painting & Decorating	6/01	2,347	3			391	782	782	392			
3	Painting & Decorating	6/02	1,781	3				297	594	593	297		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 20,714		$ 2,764	$ 5,529	$ 5,920	$ 3,843	$ 1,376	$ 985	$ 297	$	$

Facility Name & ID Number Embassy Care Center, Inc # 0038711 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council LTC 126**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,928** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **No** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **93,623**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **19,901** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.